(g) When the number of nursing facility beds licensed by the Indiana State Department of Health is changed after the annual reporting period, the provider may request in writing before the effective date of their next annual rate review an additional rate review effective on the first day of the calendar quarter on or following the date of the change in licensed beds. This additional rate review shall be determined using all rate setting parameters in effect at the provider's latest annual rate review, except that the number of beds and associated bed days available for the calculation of the rate setting limitations shall be based on the newly licensed beds.

405 IAC 1-14.6-7 Inflation adjustment; minimum occupancy level; case mix indices

Sec. 7. (a) For purposes of determining the average allowable cost of the median patient day and a provider's annual rate review, each provider's cost from the most recent completed year will be adjusted for inflation by the office using the methodology in this subsection. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be adjusted for inflation using the

CMS Nursing Home without Capital Market Basket index as published by DRI/WEFA. The inflation adjustment shall apply from the midpoint of the annual financial report period to the midpoint prescribed as follows:

Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

(b) Notwithstanding subsection (a), beginning on the effective date of this rule through September 30, 2005, the inflation adjustment determined as prescribed in subsection (a) shall be reduced by an inflation reduction factor equal to three and three-tenths percent (3.3%). The resulting inflation adjustment shall not be less than zero (0). Prior to September 30, 2005, the office may reduce or eliminate the inflation reduction factor to increase aggregate expenditures up to levels appropriated by the Indiana general assembly. Any reduction or elimination of the inflation reduction factor shall be made effective no earlier than permitted under IC 12-15-13-6(a).

(c) In determining prospective allowable costs for a new provider that has undergone a change of provider ownership or control through an arm's-length transaction between unrelated parties, when the first fiscal year end following the change of provider ownership or control is less than six (6) full calendar months, the previous provider's most recently completed annual financial report used to establisha Medicaid rate for the previous provider shall be utilized to calculate the new provider's first annual rate review. The

inflation adjustment for the new provider's first annual rate review shall be applied from the midpoint of the previous provider's most recently completed annual financial report period to the midpoint prescribed under subsection (a).

(d) Allowable fixed costs per patient day for direct care, indirect care, and administrative costs shall be computed based on an occupancy rate equal to the greater of eighty-five percent (85%), or the provider's actual occupancy rate from the most recently completed historical period.

(e) Notwithstanding subsection (d), the office or its contractor shall re-establish a provider's Medicaid rate effective on the first day of the quarter following the date that the conditions specified in this subsection are met, by applying all provisions of this rule, except for the eighty-five percent (85%) minimum occupancy requirement, if both the following conditions can be established to the satisfaction of the office:

(1) the provider demonstrates that its current resident census has increased to eighty-five percent (85%) or greater since the facility's fiscal year end of the most recently completed and desk reviewed cost report utilizing total nursing facility licensed beds as of the most recently completed desk reviewed cost report period, and the provider's census has remained at such level for no less than ninety (90) days; and

(2) the provider demonstrates that its resident census has increased by a minimum of fifteen percent (15%) since the facility's fiscal year end of the most recently completed and desk reviewed cost report and has remained at such level for no less than ninety (90) days.

(f) Allowable fixed costs per patient day for capital-related costs shall be computed based on an occupancy rate equal to the greater of ninety-five percent (95%), or the provider's actual occupancy rate from the most recently completed historical period.

(g) The case mix indices (CMIs) contained in this subsection shall be used for purposes of determining each resident's CMI used to calculate the facility-average CMI for all residents, and the facility-average CMI for Medicaid residents.

RUG-III Group	RUG-III Code	CMI Table
Rehabilitation	RAD	2.02
Rehabilitation	RAC	1.69
Rehabilitation	RAB	1.50
Rehabilitation	RAA	1.24
Extensive Services	SE3	2.69
Extensive Services	SE2	2.23
Extensive Services	SE1	1.85

405 I AC 1-14.6-9 Rate components; rate limitations; profit add on

Sec. 9 (a) The Medicaid reimbursement system is based on recognition of the provider's allowable costs for the direct care, therapy, indirect care, administrative and capital components, plus a potential profit add-on payment. The direct care, therapy, indirect care, administrative, and capital rate components are calculated as follows:

(1) The indirect care, administrative, and capital components, are equal to the provider's allowable per patient day costs for each component, plus the allowed profit add-on payment as determined by the methodology in subsection (b).

(2) The therapy component is equal to the provider's allowable per patient day direct therapy costs.

(3) The direct care component is equal to the provider's normalized allowable per patient day direct care costs times the facility-average case mix index for Medicaid residents, plus the allowed profit add-on payment as determined by the methodology in subsection (b).

(b) The profit add-on payment will be calculated as follows:

(1) For nursing facilities designated by the office as children's nursing facilities, the direct care component profit add-on is equal to fifty-two percent (52%) of the difference (if greater than zero (0)) of:

(A) the normalized average allowable cost of the median patient day for direct care costs times the facility average case mix index for Medicaid residents times one hundred five percent (105%); minus

(B) the provider's normalized allowable per patient day costs times the facility average case mix index for Medicaid residents.

(2) Beginning on the effective date of this rule through June 30, 2006, for nursing facilities that are not designated by the office as children's nursing facilities, the direct care component profit add-on is equal to zero (0). Beginning July 1, 2006, the direct care component profit add-on is equal to fifty-two percent (52%) of the difference (if greater than zero (0)) of:

(A) the normalized average allowable cost of the median patient day for direct care costs times the facility average case mix index for Medicaid residents times one hundred five percent (105%); minus

(B) the provider's normalized allowable per patient day costs times the facility average case mix index for Medicaid residents.

(3) The indirect care component profit add-on is equal to fifty-two percent (52%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day times one hundred percent (100%); minus

(B) a provider's allowable per patient day cost.

(4) The administrative component profit add-on is equal to sixty percent (60%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day times one hundred percent (100%); minus

(B) a provider's allowable per patient day cost.

(5) The capital component profit add-on is equal to sixty percent (60%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day times eighty percent (80%); minus

(B) a provider's allowable per patient day cost.

(6) The therapy component profit add-on is equal to zero (0).

(c) Notwithstanding subsections (a) and (b), in no instance shall a rate component exceed the overall rate component limit defined as follows:

(1) The normalized average allowable cost of the median patient day for direct care costs times the facility-average case mix index for Medicaid residents times one hundred ten percent (110%).

(2) The average allowable cost of the median patient day for indirect care costs times one hundred percent (100%).

(3) The average allowable cost of the median patient day for administrative costs times one hundred percent (100%).

(4) The average allowable cost of the median patient day for capital-related costs times eighty percent (80%).

(5) For the therapy component, no overall rate component limit shall apply.

Sec. 16. (a) Charity, courtesy allowances, discounts, refunds, rebates, and other similar items granted by a provider shall not be included in allowable costs. Bad debts incurred by a provider shall not be an allowable cost.

(b) Payments that must be reported on the annual financial report form that are received by a provider, an owner, or other official of a provider in any form from a vendor shall be considered a reduction of the provider's costs for the goods or services from that vendor.

(c) The cost of goods or services sold to nonpatients shall be offset against the total cost of such service to determine the allowable patient-related expenses. If the provider has not determined the cost of such items, the revenue generated from such sales shall be used to offset the total cost of such services.

(d) For nursing facilities that are certified to provide Medicare-covered skilled nursing facility services and are required by the Medicare fiscal intermediary to submit a full Medicare cost report, the office or its contractor shall remove from allowable indirect care and administrative costs the portion of those costs that are allocable to therapy services reimbursed by other payers and non-allowable ancillary services. In determining the amount of indirect care costs and administrative costs that shall be removed from allowable costs, the office or its contractor shall calculate a ratio of indirect cost to direct cost based on the direct and total therapy and nonallowable ancillary costs reported on each facility's Medicare cost report.

(e) For nursing facilities that are certified to provide Medicare-covered skilled nursing facility services that are not required by the Medicare fiscal intermediary to submit a full Medicare cost report, the office or its contractor shall remove from allowable indirect care and administrative costs the portion of those costs that are allocable to therapy services reimbursed by other payers and non-allowable ancillary services. In determining the amount of indirect care costs and administrative costs that shall be removed from allowable costs, the office or its contractor shall remove the indirect and administrative costs reimbursed by other payers based on a statewide average ratio, excluding hospital based facilities, of indirect costs to direct costs for such therapy and ancillary services, as determined from full Medicare cost reports. The statewide average ratio shall be computed on a statewide basis from the most recently completed desk reviewed annual financial report and shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

405 IAC 1-14.6-17 Allowable costs; wages; costs of employment; record keeping; owner or related party compensation

Sec. 17. (a) Reasonable compensation of individuals employed by a provider is an allowable cost, provided such employees are engaged in patient care-related functions and that compensation amounts are reasonable and allowable under this section and section 18 of this rule.

(b) The provider shall report on the forms prescribed by the office, all patient-related staff costs

405 IAC 1-14.6-22 Administrative reconsideration; appeal

Sec. 22. (a) The Medicaid rate-setting contractor shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate or allowable cost determinations, the provider must request an administrative reconsideration by the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor within forty-five (45) days after release of the rate as computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the rate, amend the challenged procedure or allowable cost determination, or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the provider of its final decision in writing, within forty-five (45) days of the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (d).

(b) If the provider disagrees with a rate redetermination resulting from a financial audit adjustment or

reportable condition affecting a rate, the provider must request an administrative reconsideration from the Medicaid financial audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider or authorized representative of the provider and must be received by the Medicaid audit contractor within forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid audit contractor shall evaluate the data. After review, the Medicaid audit contractor may amend the audit adjustment or reportable condition or affirm the original adjustment. The Medicaid audit contractor shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the Medicaid audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(c) If the provider disagrees with a rate redetermination resulting from a recalculation of its CMI due to an MDS audit affecting the established Medicaid rate, the provider must request an administrative reconsideration from the MDS audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider or authorized representative of the provider and must be received by the MDS audit contractor within forty-five (45) days after release of the